www.tsbs.cc
1-877-897-8283

**School Health and Related Services Program** **School Year :** _____

# SHARS Physical Therapy Session Notes

Optional

(Please Print)
**Practitioner:** _____ **Student:** _____ **Annual ARD Date:** _____

**Credentials:** _____ PT _____ LPTA **DOB:** _____ **# of Sessions:** _____

**Prescribing Physician: (MD)** _____ **Medicaid #:** _____ **Time (Minutes per session):** _____

**Prescription Date:** _____ **School District:** _____ **Co-op/SSA:** _____

Goal/Objective from IEP (Focus for Direct Services): _____

| Date | Svc Code | Start/Stop Time | Billable Time | Activity | Related Goal | Observations | Initials |
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**Start/Stop Time:** time of day (i.e.: 10-10:30 am)
**Billable Time**: Total minutes/hours ( i.e.: 30 min)
**Svc Code**: **E** = Evaluation, **G** = Group Therapy, **I** = Individual Therapy

**Signature:** _____
(Required)